CHAMPVA POLICY MANUAL

CHAPTER: 2
SECTION: 15.1
TITLE: EVALUATION AND MANAGEMENT SERVICES (OFFICE VISITS) GENERAL

AUTHORITY: 38 CFR 17.270(a) and 17.272(a)

RELATED AUTHORITY: 32 CFR 199.4(c)(2)(iv)

I. EFFECTIVE DATE

A. Effective January 1, 1992, the American Medical Association Current Procedural Terminology (CPT) evaluation and management service codes (i.e., visit codes) were revised. The former CPT 90000 series codes were replaced by a new CPT 99000 series. The new codes were adopted for CHAMPVA claims processing for claims submitted on or after January 1, 1992.

B. Effective 1-1-98, Evaluation and Management Service Visits allowable amount is included in the procedure payment and will not be reimbursed as a separate charge.

II. PROCEDURE CODE(S)

77750-77799, 90935-90947, 94010-94772, 95115-95180, 99050, 99052, 99054, 99056, 99058, 99201- 99215, 99321-99333, 99341-99350, 99358-99359, and 99381-99397

III. POLICY

A. Evaluation and management (E&M) services are covered when provided by an individual professional provider for the diagnosis or treatment of a specific illness or condition or set of symptoms. Visits are classified according to the following factors:

1. medical history,
2. examination,
3. medical decision making process,
4. counseling,
5. coordination of care,

6. nature of presenting problem, and

7. time.

B. Some evaluation and management visits are classified according to whether the patient is new or is an established patient. A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. Only one new patient visit for a beneficiary to a provider is covered. The following groups of evaluation and management codes are specific for new vs. established patients:

99201-99215, 99321-99333, 99341-99350, and 99381-99397

C. If the claim does not specify the level of the visit, the service will be processed and paid under CPT procedure code 99202 for a new patient and 99213 for an established patient. If the claim does not specify whether the patient is new or established, the patient will be considered to be an established patient.

D. See Chapter 2, Section 29.17, *Evaluation and Management Services (Office Visits) with Surgery.*

IV. POLICY CONSIDERATIONS

A. No additional payment will be allowed when any of the services listed below are billed in conjunction with an E&M visit. Reimbursement will be limited to the allowable charge for the E&M visit only (combine the charge and base payment on the maximum allowable charge for the E&M visit.) If the level of the visit is not specified, the service will be processed and paid under CPT procedure code 99202 for a new patient and 99213 for an established patient.

1. minor dressing,

2. oscillometric testing,

3. ostomy care,

4. prostate massage,

5. blood pressure determination,

6. topical 5-FU (fluorouracil) treatment,

7. eye washing,

8. ear irrigation,

9. pelvic examination,

10. rectal examination,

11. urethral catheterization,

12. removal of fecal impaction,

13. removal of cerumen,

14. cauterization of cervix by chemical agents,

15. cast application not involved with surgery, and

16. dressing changes.

B. Generally, when additional charges are made for services provided beyond the provider's normal treatment hours, CHAMPVA would reimburse for these charges up to the prevailing rates established for these charges. An exception would be when the provider's treatment hours consistently extend beyond what would generally be considered normal treatment hours to accommodate the patient, e.g. urgi-centers. When a provider bills additional charges under these arrangements, no payment shall be made for these additional charges.

C. Only the E&M service with the highest prevailing rate will be payable when multiple evaluation and management services are billed on the same day by the same provider. If review indicates that such services were billed by different professional providers, each service is payable.

Note: If an abnormality or a preexisting problem is encountered or addressed in the course of the office visit, and if the abnormality/problem is significant enough to require additional service, then modifier –25 could be added to the Office/Outpatient code. Modifier –25 is used to indicate that the same physician provided a significant, separately identifiable E/M service on the same day of the procedure or other service. (Example: A patient presents for a GYN exam and at the time of the office visit, the physcian also removes a skin lesion on the arm.)

D. When a surgical procedure is performed at the time of an E&M service, only the surgical procedure is payable unless modifier –25 is used and review indicates that the patient's condition required the E&M service or a separate diagnosis justifies payment of the E&M service (see Chapter 2, Section 29.17, *Evaluation and Management Services (Office Visits) With Surgery)*.

E. For office visits billed in conjunction with PUVA therapy, see Chapter 2, Section 30.11, *Phototherapy and Photochemotherapy (PUVA)*.

F. Medical visits will be denied when billed with specific non-surgical procedures.

V. EXCLUSIONS

A. E&M services for a routine physical examination are not covered (see Chapter 2, Section 23.2, *Routine Physical Examinations)*.

B. For patients who have been determined to be receiving custodial care, E&M visits related to the custodial condition are not covered.

C. Some procedures include routine evaluation and management services. Therefore, E&M services are not payable when billed with any of the following procedures:

77750-77799, 90935-90947, 94010-94772, and 95115-95180.

D. Procedure codes 99050, 99052, 99054, 99056, 99058, 99358, and 99359 are not reimbursed separately as payments for these services are included in the payment for other services.

END OF POLICY